California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 10 - Technical Specifications

Issuer Name:

Instructions:

Please respond to the following questions, confirmations and requests for information. Responses should immediately follow the associated question/request.

GENERAL

1. *Provide your active vision membership, as of July 1, 2012, in the state of California. (please define by market segment; Individual, Employer-sponsored vs. Voluntary)*

2. *Briefly describe three attributes of your organization that you believe distinguish you from your competitors.*

3. *Describe up to three examples of your organization's successful innovations to improve service quality and reduce costs. Discuss scope of the innovation, targeted population, goals, outcomes (quality and cost), and scalability and/or plans for dissemination.*

4. *Do you offer discount programs related to non-covered services (e.g. laser surgery)? If so, explain*

5. *Please provide a brief description of any outside vendors that will be utilized.*

6. *Provide the physical location of all administrative teams (claims processing, member services, etc) that you propose to serve The Exchange.*

ACCOUNT MANAGEMENT SUPPORT

7. *Describe whether the account team members (e.g. implementation manager, claims specialist, member services manager, etc.) will be dedicated to the Exchange. If the account team will have other responsibilities, how many other clients will they be responsible for and what percentage of their time will be committed to the Exchange?*

IMPLEMENTATION

8. *Confirm that a dedicated implementation manager will be assigned to lead and coordinate the implementation activities with the Exchange? If you cannot confirm, please explain.*

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

9. ***Describe the services and support you will provide during the implementation process and what information/resources will be required of the Exchange. Be specific***

10. ***Should your organization be selected, explain how you plan to accommodate the additional membership (discuss anticipated hiring needs, staff reorganization, etc.):***

- Member Services

- Claims

- Financial / Administrative Information Technology

- Other (describe).

SERVICE AND MATERIALS

11. ***Please answer <u>Yes or No</u> on what services are performed in your basic/routine eye exam:***

- Vision history
- Visual Acuity
- General eye health
- Glaucoma testing
- Eye Muscle assessment
- Refraction
- Patient education

12. ***Are there circumstances in which a participant's selection of discounted eyewear is limited to a portion of the total supply? If so, please elaborate.***

13. ***Describe the coverage/selection for frames which is available to the Exchange through your providers. (Discuss the quality of frames, variety of styles, ability to service all ages, consistency of frames between different provider offices)***

14. ***What is the average size of inventory in your provider locations?***

15. ***Describe the coverage/selection of eyeglass lenses available to the Exchnage from your network. Address single vision, bifocal, trifocal, glass, plastic, impact resistant, high refractive power lenses, high-index, blended bifocals, progressive bifocals, photochromic, tinted, antireflection, etc.***

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

16. *Describe the coverage/selection of contact lenses available to the Exchange from your network. Indicate the type and extent of coverage for daily wear soft lenses, hard contacts, extended wear and disposable.*

17. *Is there a limit on the number of services or supplies that can be purchased at the discounted price?*

18. *Can a participant receive an eye exam at one provider and the glasses/lenses from a different provider?*

19. *Are you able to provide special vision services such as Visual Display Terminal occupational coverage, safety lenses/eyewear, etc?*

20. *Are there any special circumstances required for a participant to visit a network ophthalmologist? If so, please provide details and indicate whether preauthorization is required.*

ACCOUNT ADMINISTRATION

21. *Confirm the exchange will be provided a dedicated claims processing unit. If you cannot confirm, please explain.*

22. *Confirm that the Exchange will retain the right to annually audit/assess the plan administrator's compliance with the terms of the contract, including but not limited to a claims audit or audit for cause of irregular activity, either directly or through its authorized agents. Confirm you will provide 2 years worth of claims experience with no limit on the number of claims that may be reviewed and that any audits will be completed with no additional cost to the Exchange.*

23. *Describe your claims administration procedures. Are claims forms necessary?*

24. *What guarantees do you provide to ensure members will not be balance billed for in-network exam services?*

25. *Confirm you will accept the enrollment business rules implemented by The Exchange. If you cannot confirm, please explain.*

26. *How do you identify and address inappropriate patterns of treatment? Please provide details.*

27. *Describe your fraud & abuse program.*

Issuer Name:

28. *What steps do you take to protect patient privacy? How is Protected Health Information (PHI) handled?*

MEMBER SERVICES

29. *Confirm that the Exchange will be provided a dedicated member services unit. If you cannot confirm, please explain.*

30. *Confirm you will produce and distribute ID cards within 48 hours of receipt of clean eligibility data. If you cannot confirm, please explain.*

31. *Confirm you will provide a dedicated IVR (interactive voice response) member services number? If you cannot confirm, please explain.*

32. *Is there a mechanism for members to quickly reach a live member services representative? Please describe.*

33. *How are after-hours/holiday telephone inquiries handled? (Recorded message by Plan (i.e. Hours of operation and directors for emergency), Interactive Voice Response System (IVR), Live Response, Health Plan Internet Website, Other.)*

34. *Will you make the customer service line available to participants prior to the effective date?*

35. *Confirm you are prepared to offer access to a demo member web-site. Note that finalist vendors will be asked to provide this.*

36. *Indicate which member services options are available via IVR, Phone Representative, and Internet (Select all that apply).*

Option	IVR	Phone Rep	Website
Verify eligibility			
Enrollment changes			
Check claims status			
Request ID card			
Request benefit summary			

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

Review Explanation of Benefits			
Access customer service via email			
Obtain a history of vision claims			
Provider referrals			
Complete satisfaction survey			
Other (specify)			

37. ***Indicate the ways in which your member services organization is able to accommodate the special needs of enrollees. (Check all that apply)***

❑ *No special accommodations*

❑ *Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hear impaired*

❑ *Translation to non-English languages*

Language	No Translation Available (check if appropriate)	Translation performed in-house (check if appropriate)	Translation Contracted (specify contracted organization's name)
Spanish			
Vietnamese			
Cantonese			
Mandarin			
Armenian			
Russian			

Issuer Name:

Tagalog			
Hmong			
Korean			
Farsi			
Arabic			
Cambodian			
Other (please specify)			

38. ***Confirm you will modify your Customer Service operations, as necessary, to meet the requirements of The Exchange with regard to the following:***

- Operating hours (Exchange requires 7am to 7pm; 7 days per week)
- Staffing requirements
- Training criteria

    If you cannot confirm, please explain.

CARE MANAGEMENT

39. ***Confirm that the following programs/services will be made available to Exchange enrollees in 2014***

    ____Risk assessments

    ____Disease management programs

    ____Care reminders

40. ***Do you offer a health & wellness component to your vision program (e.g. diabetes awareness program)? If so explain?***

Issuer Name:

41. ***Do you provide preventive care reminders? If so, how are they distributed?***

   ___Reminders are made via e-mail

   ___Reminder letters are sent

   ___Reminder telephone calls are made

42. ***Do you coordinate with Medical programs with regard to high risk individuals? If so, explain.***

43. ***Do you offer ICD-9 reporting?***

44. ***Outline your approach to pro-actively identify Exchange enrollees who are actively in need of covered vision services (preventive and diagnostic or other) and ensure service are provided.***

COMMUNICATIONS & EDUCATION

45. ***Provide a description of your standard communications materials.***

46. ***Will you draft and distribute introductory communications pieces prior to open enrollment?***

47. ***Indicate which member tools/information you offer and how they may be accessed (IVR, Web, Member Services Representatives, etc.).***

	Offered?	Access
Plan Design Information		
Personal Claim Information		
Explanation of Benefits		
Estimate Costs for Services		
Actual Cost of Services		
General Healthcare Information		

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

Health Library		
Provider Search		
Provider quality info		

Plan comparisons		
Frequently Asked Questions		
Other		

48. *Please indicate which plan sponsor tools/information you offer and how they may be accessed (IVR, Web, Member Services Representatives, etc.).*

	Offered?	Access
Enrollment Administration		
Eligibility Administration		
Provider Performance		
Plan Policies		
Plan Design		
Utilization Analysis		
Cost & Trend Analysis		
Provider Search		
Provider quality info		
Plan comparisons		

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

Frequently Asked Questions		
Other		

49. *Confirm you will provide the plan sponsor training regarding use of the online tools. How will you approach this training?*

50. *Confirm the online tools provided by your organization for the Exchange program staff and members will be available 99.5 percent of the time, twenty-four (24) hours a day, seven (7) days a week? If you cannot confirm, describe level of guaranteed availability.*

PROVIDER NETWORK

51. *Do you own your provider networks or contract with other organizations? If you contract with other organizations, please provide those organizations' names.*

52. *What is the name of your network?*

53. *Does your network consist of both independent providers and retail chains?*

54. *What percentage of locations provides both exams and materials?*

55. *How are providers compensated for their services?*

56. *Confirm your provider network directory is available online.*

57. *Confirm the following indicators are included for each provider within your directory:*

- Accepting New Patients?
- Services Provided
- Specialties
- Board Accreditation
- Languages Spoken
- Hours of Operation
- Accept Credit Cards?
- Other - please describe

58. *How often is your online directory updated? How often is your printed directory updated?*

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

59. *Please provide an indication of network access by completing the following tables for each rating region.*

Rating Region		
Type of Dentist / Specialist	**Number of Providers**	**Number of Providers with Open Practices**
Optometrist		
Opthalmologist		
Optician		
Other (explain)		
Total		

60. *What is your network growth plan for the California network in 2014?*

61. *Describe your process for recruiting new providers, including how you identify providers for recruitment.*

62. *What percentage of your network providers is not accepting new patients?*

63. *What percentage of your network providers have office visit waiting times in excess of 30 days?*

64. *What is your network turnover rate or rate of termination? What is the provider initiated rate of termination? What is the network initiated rate of termination?*

65. *Describe in detail your credentialing and re-credentialing processes.*

66. *Provide a description of the quality indicators used to evaluate your provider network. Do you have an incentive program for network providers that are evaluated favorably against your quality indicators?*

California Health Benefit Exchange
Solicitation for Supplemental Vision Benefits
Attachment 11 - Technical Specifications

Issuer Name:

67. *Describe the steps you take to investigate Member-reported quality of care issues regarding a Provider. Have you terminated network dentists based on your investigation of a member-reported quality complaint? If so, please describe.*

68. *Are out-of network benefits offered? If so, how are these reimbursed?*

69. *Describe how exams, lens and frame costs are discounted in your program.*

SYSTEMS AND DATA REPORTING MANAGEMENT

70. *Confirm your organization is compliant with all applicable federal and state regulatory reporting requirements (e.g. HIPAA, etc.)*

71. *Confirm you will provide reporting as deemed necessary by The Exchange related to utilization, costs, quality, operations and agreed upon performance guarantees.*

72. *Confirm your organization will build all required data interface capabilities with the Exchange's eligibility and enrollment systems and will report on transactions as deemed necessary by The Exchange*

73. *Please describe any concerns you have around reporting requirements The Exchange may develop.*